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**BACKWARD DISLOCATION OF THE UPPER END
OF THE ULNA.**

OLD. COMPLETE DISLOCATION OF THE ULNA ALONE, WITH ROTATION AROUND
THE HEAD OF THE RADIUS. OPERATION: GOOD RESULT.

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BACKWARD dislocation of the upper end of the ulna alone, when complete, seems to be a rare lesion. Stimson, who gives an admirable classification of these injuries, describes three forms of dislocation of the upper end of the ulna.¹ The first form is that in which the displacement is slight; the ulna is carried backward and rotated slightly around the radius; and then, by adduction of the forearm or by upward movement of the ulna, the coronoid process passes behind the trochlea. In the second form, the coronoid process passes upward until it engages in the olecranon fossa. This requires that there shall be still more adduction of the forearm than takes place in the first variety. In the third form the rotation of the ulna around the radius continues until the ulna lies behind the radius.

Concerning the first form, it is the most common, and is spoken of as "incomplete." Stimson has been able to find only two recorded cases of the second form (the cases of Malgaigne and Wilson). I have not been able to find in literature a report or a description of any cases of the third form. The case herewith reported is such a one.

K. K., male, aged thirteen, jumped and fell from a wagon, striking upon his hand, forearm, and elbow. He suffered much pain; was unable to sleep for two nights; deformity of the elbow was recognized, and soon was obscured by swelling. He was not seen by a surgeon, but was treated with liniment. The elbow was stiff and painful. He was not able to use the arm. Gradually the swelling subsided. Pain was always present when the elbow

¹ Fractures and Dislocations.

was much moved. He was otherwise well. Nine weeks later the boy was taken to Dr. E. W. Skelton, who recognized the nature of the lesion and sent him to me at the German Hospital.

Examination showed the right ulna entirely absent from the trochlear surface. The radius was in its normal place. The upper end of the ulna could be felt lying posterior to the radius. External to the ulna, and connected with the outer condyle of the humerus, could be felt an irregular bony mass which was interpreted as the callus of a fracture of the condyle which had united in malposition. The forearm was in a position of flexion at an obtuse angle of about 150 degrees. Flexion and extension were possible through an arc of about 10 degrees. Supination and pronation were possible through only about one-fourth of their normal excursion. All of these movements were painful as they approached their limits. There was no œdematous swelling. The arm had undergone considerable atrophy. The X-ray plates showed the above-described conditions (Fig. 1).

Operation, ten weeks after injury: A long incision was made directly posterior to the displaced ulnar head. The ulna was found rotated just 90 degrees, so that the sigmoid notch instead of looking forward looked inward. The notch and the trochlear surface were covered with new connective tissue and adherent capsule. The connective tissue was dissected away from the articular surfaces; but when everything was freely cleared, it was impossible to rotate the ulna into place. Attention was then directed to the bony mass connected with the outer condyle. It was found that there had been no fracture as was surmised, but that the mass was an exostosis of new bone which had been thrown out beneath the stripped-up periosteum in front of the condyle. When this exostosis was chiselled off, the ulna rotated back into normal position with perfect ease. The wound was closed, and the arm was put up at a right angle in plaster of Paris.

At the end of two weeks, passive motion was begun; and at the end of three weeks the patient was allowed to use his arm. Motion of the joint steadily improved. There was no pain. At the end of two months the elbow functionated well excepting that flexion and extension stopped short of normal. The arm was strong, supple, and useful for every function for which it was called upon.

At the present time the arm is normal in both its anatomy and physiology excepting that extension and flexion cannot be carried quite to their full extent.

FIG. 1.



Outward dislocation of upper end of ulna. The upper end of the ulna is dislocated posterior to the head of the radius, and at the same time is rotated 90 degrees, so that the sigmoid notch and the coronoid process look inwards.



